Health Committee

Oral evidence: Work of the Secretary of State for Health, HC 446

Tuesday 15 September 2015

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Watch the meeting

Members present: Dr Sarah Wollaston (Chair); Dr James Davies; Andrea Jenkyns; Rachael Maskell; Andrew Percy; Paula Sherriff; Emily Thornberry; Maggie Throup; Helen Whately; Dr Philippa Whitford.

Questions 1-120

Witnesses: **Rt Hon Jeremy Hunt MP**, Secretary of State for Health, **David Williams**, Director General, Finance, Commercial and NHS, and **Jon Rouse**, Director General, Social Care, Local Government and Care Partnerships, Department of Health gave evidence.

Q1 Chair: Good afternoon. Thank you very much for coming to the Health Committee this afternoon and welcome to the Secretary of State. Could you introduce yourselves to those who are following from outside the room, starting with Mr Rouse?

Jon Rouse: I am Jon Rouse. I am director general for social care, local government and care partnerships at the Department of Health.

Chair: Thank you.

Jeremy Hunt: This is David Williams, the new finance director at the Department of Health, perhaps the most difficult job in Whitehall.

David Williams: Thank you.

Chair: Thank you very much. We are going to start today with Rachael Maskell.

Q2 Rachael Maskell: Good afternoon. How are you going to balance your future ambitions for the NHS with the current financial restraints?

Jeremy Hunt: It is a really good question to kick off with because, in a way, it sums up the whole approach to health policy that we as a Government have decided to take. The first thing is to acknowledge that the financial pressures on the NHS are the worst they have ever been in its history. There is a triple whammy of the ageing population, which means that we will have about 1 million more over-70s by the end of the Parliament than we have today, which is obviously massive in its impact; the financial pressure, which means the Government are not able to increase spending in real terms on the NHS by the amounts they have done historically—something we have had to get used to over the last five years; and raised expectations from people who use the NHS about accessing it more easily, but

also raised expectations post-Mid Staffs in terms of quality and standards of care. The choice that I have made, and I hope this would have the support of all parties, is that in that situation you can either retrench, essentially try to tread water and desperately try to maintain services at their current levels but not really change much, or you can be ambitious and say, "These are massive challenges, but post-Mid Staffs we want the NHS to offer the safest and best quality healthcare anywhere in the world and we are determined to do what it takes." I believe we can do that and that that journey has the support of NHS staff, but I do not want to pretend that it is going to be easy.

Q3 Rachael Maskell: If I can push you a little further on that, we are expecting a rise in trust deficits by the end of the year, predicted at possibly £2.1 billion, and at the same time you are talking about introducing seven-day working, expanding services. Is holding to that intention living in reality?

Jeremy Hunt: I think it is, because first of all the reality of the NHS is 1.3 million people who are passionately committed to doing the right thing for patients. If we did not do something about the 11,000 excess deaths that we have because of the weekend effect in hospitals, people would say it was a betrayal of what the NHS stands for. If you look at the financial situation, it is tough, but the deficit that the hospital sector—the providers—has is one part of the picture. Last year, it was an £822 million deficit, but the commissioners—the people who spend the money—had an £855 million surplus. I know it will be tough, but I am confident that the NHS overall will balance its books by the end of the year, and—

Q4 Rachael Maskell: Can I come in on that? Providers at the moment are saying that the reduction in the tariff is having quite a detrimental impact on delivery of services, so providers are not recognising that we are going to get there at the end of the year.

Jeremy Hunt: It is tough for everyone in the NHS. It is certainly tough for providers, but the point is that the areas where we are not delivering care as safely as we should are areas that end up costing us money. It is very noticeable that some of the most efficient hospitals in the NHS, often with surpluses, are hospitals offering seven-day care, like Northumbria. There is an inherent inefficiency about winding down all your operating theatres on a Friday afternoon and then having to crank them up again on a Monday morning, apart from the impact on patients who are stuck in hospital over the weekend when they could be discharged and the impact on patients who get delayed in A&E departments because there is not a bed to admit them to. In a lot of these areas, the right thing in terms of improving patient safety also reduces costs to the NHS.

Q5 Rachael Maskell: We have had the conversation more or less on the basis of flat-lining, but in the Five Year Forward plan it was about £22 billion-worth of efficiency savings. Simon Stevens, when he came here just before the summer, highlighted that it would be built around prevention, managing prices and increasing productivity. How do you see that spreading out in the light of the current pressures on delivery of services?

Jeremy Hunt: First of all, it is important to say that it is £22 billion of efficiency savings, not £22 billion of cuts in absolute terms. In real terms, the NHS budget will go up by £10 billion a year during the course of this Parliament. Demand for NHS services, because of the ageing population, will go up by more than that if we do things the way we currently

do; we think around £30 billion. That is where the £20 billion to £22 billion of efficiency savings comes from. We are going through the biggest exercise in the NHS's history, looking at where the sensible places to make efficiencies are—everything from procurement, where we know that one trust will spend £1.27 on a pair of surgical gloves and another trust will spend 50p on exactly the same pair of gloves; to the use of land where we think we could save potentially £1 billion a year; to pay restraint, which is obviously very challenging, given how hard NHS staff are working; and to potentially one of the most important areas of all, which is reducing demand on the NHS by tackling diseases earlier. We know that catching a cancer at stage 4, apart from the fact that it is terrible for the patient and their chances of survival are much less, costs the NHS a lot more than catching a cancer at stages 1 or 2, and yet 20% of our cancers are diagnosed in A&E departments at the moment. There is a big opportunity, so we are bringing all of that together.

Q6 Rachael Maskell: I want to go further down that line of looking at the impact of costs. Obviously we know the pressures are real, but I have not really heard about the scheduling of the £22 billion efficiency savings you are planning. Perhaps you could tell us how you see that forecast.

Jeremy Hunt: The savings have to be made during this Parliament. That is an annual figure. We do not have to make savings of £22 billion next year, but by the time we get to 2019, 2020 and 2021 we will need to be, on an annual basis, making those savings. The profiling of those savings depends also on the profiling of the £8 billion of additional money on top of the £2 billion that is going in this year. That is being negotiated with the Treasury as part of the Comprehensive Spending Review, so I do not know the answer to that question. But we are, as a Department, doing a lot of work now to try to understand how many of those savings can be realised and how quickly, and which are realistic ones and which are not. That is obviously taking up a huge proportion of my time.

Q7 Rachael Maskell: What happens if you cannot reach that target?

Jeremy Hunt: That is a very difficult question to answer. Let me say I am confident we will. We have to.

Q8 Rachael Maskell: Organisations like the Nuffield Trust are not.

Jeremy Hunt: Organisations like the Nuffield Trust and indeed the King's Fund, who were talking about this today, have not had a chance to see the very detailed work that we are doing. They will see it in due course and then, as they always do, they will come to their own independent judgment as to whether they agree.

Q9 Rachael Maskell: I think providers are quite sceptical as well in the light of the budget deficits they are facing at the end of this year. I am trying to get some realism on those figures.

Jeremy Hunt: Yes. We are working through those figures. It is part of the process of the CSR to work out what we think it is possible to ask the NHS to deliver, to agree that with NHS England and then to agree it with the Treasury. We are in the middle of that process now. When that process is complete, obviously we will then need to go to the NHS, rather

as David Nicholson did with the Nicholson challenge, which successfully saved about £19 billion over the last Parliament. We will go through that same process with trusts. You are right to say that we need to carry trusts with us in this process and you are right to say that there is currently some scepticism about the ability to do that, which is difficult to assuage when we are in the middle of the process. It has to be a partnership between me, NHS England and trusts. Indeed, it has to be a partnership with staff because, in the end, they are the ones who know better than anyone else where the efficiency savings can be made if we want to reinvest that money in better patient care, as we all do.

Q10 Rachael Maskell: Can we really achieve these efficiency savings, these cuts to some of the services you highlighted, as well as maintaining quality of care?

Jeremy Hunt: I believe we can do better than maintain quality of care; we can improve quality of care. I have said that I want the NHS to have the safest hospitals in the world. I want us to blaze a trail in terms of our—

Q11 Rachael Maskell: But if you will excuse me, there are some practicalities to that rather than just pronouncing it. There is obviously the staffing on the ground. It is about the resources available. It is about the increased capacity that is going to be needed. How is that going to be achieved?

Jeremy Hunt: I will take the last pronouncement and talk to you about the detailed plans that we are doing to try to make that happen. We will shortly be publishing a detailed plan for the roll-out of seven-day hospital care to eliminate the 11,000 excess weekend deaths, or deaths from the weekend effect. It will be a staged programme over the next four years so people will be able to see which parts of the country will pioneer the programme and where we go from there.

Q12 Rachael Maskell: But that will cost 2% more on the budget, so presumably, as a result, there will be losses elsewhere in the system.

Jeremy Hunt: There may be some up-front money that is needed to do that, but there is also a lot of evidence that there are efficiency savings to be made from offering truly seven-day care. We will publish those plans. If I look at the other things that are improving safety, we have the new CQC inspection regime, which has got every trust board in the country thinking about safety in a way that has not happened before. I have said to Parliament that I intend to publish avoidable deaths by hospital trust by next spring. Again, actually understanding whether a death in a hospital was avoidable or unavoidable is a core part of what a hospital does, and these are not necessarily things that cost money. It is much more about—equally as difficult as the money issue—creating the right culture, a culture where NHS staff feel supported to speak out if they have concerns, and where we move away from the problem that we have at the moment in too much of the NHS where staff worry that if they make a mistake and are open about it they might get fired. That may have happened at some of the places where we have had real tragedies—Mid Staffs and Morecambe Bay; staff knew something had gone wrong but did not want to co-operate because they were worried that the NHS would draw the wrong conclusions. We need an honesty culture, not a blame culture. That is a long way of saying that it is not just about money if we are going to improve the quality of care.

Rachael Maskell: There is obviously something about hands on the ground, but I will hand over to my colleague.

Chair: Thank you. Helen would like to come in on this group of questions as well.

Q13 Helen Whately: Thank you very much. You were talking about the ways that the £22 billion efficiency improvement can be achieved, and clearly we have some information about the broad areas of opportunity, but even, for instance, your procurement example is quite difficult to achieve. Though it sounds obvious, it takes some time to do that at the front line. What mechanisms are in place or planned in order to enable this scale and pace of change?

Jeremy Hunt: That is absolutely the question, and if we are honest we should be a bit sobered by the fact that people have been talking about sorting out NHS procurement for a very long time and not a huge amount has changed. On that particular example, Lord Carter—Patrick Carter—has been doing very detailed work where he took a group of around 20 hospitals and got them to share data about exactly how much they were paying for different items; that is where my numbers came from just now. He has a team of people who, by the end of this month, will communicate with every trust and tell them the amount of money they think could be saved in their trust from improved procurement, and then the trust will work with Lord Carter's team between now and Christmas to agree a figure because—to echo the comment from Ms Maskell—there has to be a joint effort to make this happen. It has never happened before, but they will then have an agreed amount of money that their trust agrees they can save. You are absolutely right to say it is not instant, because you have to renegotiate supply contracts and so on and so forth, but we think that just on procurement we could get a saving of at least £1 billion.

There is a bigger saving in terms of increasing the efficiency of rostering. Staff costs are around 70% to 75% of the costs of any trust, but the way that staff are rostered is often not done terribly efficiently. You can look at brilliant examples like Northumbria where Jim Mackey, the chief executive, knows what is happening in terms of rostering in every corner of his hospital every day, and then there are other trusts that do not have a grip on whether they are deploying staff in the places where they are needed most. This is all a process. Obviously it is very important to accelerate the pace of change in these areas, but we are confident that we will be able to make some very big savings next year, and confident of the support of trusts when we communicate that. Communication will necessarily need to happen after the spending review is announced, and that will be the start of a big process with the NHS when we share the plans with them.

Q14 Helen Whately: You gave some indication of the plan for the procurement opportunity. Simon Stevens gave us an indication before the summer that about half the opportunity was in provider efficiencies outside procurement. What are the mechanisms to make that happen at pace?

Jeremy Hunt: A very big part of that efficiency is around the use of technology. If you look at the staff cost we talked about—such a huge chunk of a typical hospital's costs—and then look at the amount of contact time a nurse has with individual patients, it varies across the NHS from as low as 35% or 40% up to 60% or 70%. There are hospitals in the United States, such as the Virginia Mason hospital in Seattle, one of the safest hospitals in the world, where they have managed to get their nurse contact time up to 90%. That is done by saving nurses' time from all the bureaucracy of filling out forms, which I am sure

you are very familiar with from your work in a previous incarnation. There is a huge amount of wasted effort. I spoke to a nurse at the George Eliot who told me that she spent two thirds of her time in the afternoons in A&E departments filling out forms trying to get patients admitted. That is another big area. But there are lots of areas like that.

Q15 Helen Whately: Is there a plan for some kind of transformation fund, as the King's Fund and others have called for, in order to jump-start these kinds of opportunities and make sure they happen at scale, and that there is learning across the system as well?

Jeremy Hunt: We may have a central tech fund to try and stimulate investment in technology because that is a very key objective for the next few years. We are investing already in transformation, in the models of care through the vanguards programme, into which we put £200 million this year. That was announced in the autumn statement. There will be up-front investment in transformation, but we have to be honest with the NHS as well and say that we simply do not have the resources for a very generous double-running process whereby we invest all the money that is needed for the new models of care and the transformation while the entire old system carries on as it always did. It would be lovely to be able to do it in that way, but the reality is that we do not have enough to do that so we will need to find some of that money from efficiency savings.

Q16 Helen Whately: You alluded to this earlier when talking about the profiling of the efficiency savings and the question of when the £8 billion increase will come in. Could you give us some insight into what you would like to see included in the Comprehensive Spending Review for health and social care?

Jeremy Hunt: Yes. Without disclosing the full length of my list of asks to the Treasury, maybe I could give you some principles that would be a good indication of my priorities. First, it is very important that we have enough to secure the basics of NHS performance, which is under pressure. It is holding up very well considering all the pressures it is under, but a pretty core part of our promise to the public is to maintain performance in A&E departments, waiting times for operations and so on. I have said that a very big priority of mine is the transformation of general practice and the recruitment of 5,000 GPs—a 15% increase, the biggest increase in GPs in the history of the NHS. That is a particular area of pressure. I am very keen to continue to improve mental health services. Norman Lamb, when he was Health Minister, did a fantastic job championing mental health and I want to make sure that we continue his good work, which I think his successor Alistair Burt is very committed to doing. It is very important that we have a settlement that allows and supports the full integration of the health and social care systems, which is a manifesto commitment of ours, but also incredibly important.

I think it is really important that we continue the fantastic progress towards safe care in our hospitals. Mid Staffs was a terrible moment. I do not just want it to be a blip where we have an inquiry and a lot of self-flagellation in public by the NHS, agree to learn a few lessons and then move on. I want it to be the start of a process whereby we blaze a trail across the world for the quality of the care that we give, and I think we can do that. Those are the priorities that I am very keen to secure in this spending round.

Q17 Helen Whately: On your final point about Mid Staffs and the culture, given the financial pressure and the need to find efficiencies that NHS organisations are under at the moment, how will you make sure that we do not return to the culture that happened in some hospitals like Mid Staffs, which focused on cost control, but instead have quality of care and patient experience as the priorities?

Jeremy Hunt: That is something I think about every single day. It is quite interesting that Mid Staffs were actually hitting their A&E target for the majority of the time that they were delivering such appalling care. One of the reasons that they were delivering poor care was cost-cutting by the management, not because the NHS budget was being cut but because the trust wanted to become a foundation trust and they were told that the finances needed to look a certain way in order to do that. So they pared down nursing staff. The rather difficult answer to that question is that when we are trying to make these £22 billion of efficiency savings they have to be smart savings, not stupid savings. The old way for some trusts—by no means all trusts—was to balance the books by slashing nursing staff, particularly in some of the elderly care and dementia wards, and that led to some real tragedies. The smart way is to invest in safer care, which we know costs less. We know that if you botch an operation—I am using non-clinical language—people stay in hospital for longer and it ends up costing the NHS more. It is a much harder thing to find smart efficiencies than to do the quick and dirty thing, but in the end that is the sustainable way to low cost. The path to lower cost is the same as the path to safer care, and we have to get the message out to the NHS that it is not one or the other; it is something that we have to do together.

Helen Whately: Thank you.

Q18 Emily Thornberry: In the same week as we learned that there was going to be a £1.2 billion bail-out for the hospital trusts, we also learned that total spend on GPs had gone down for three years in a row. There is a bail-out for hospital trusts, but would it not be a good idea for there to be some sort of bail-out for GP practices in particular circumstances, such as if they are needing to renegotiate a lease, if they are getting desperate? As you know, there is a GP surgery in my constituency which could not negotiate the lease, asked NHS England for help, did not get it and closed down. Now NHS England have locums in and everything else, keeping the practice going for a few months while something else is found. But if there had just been a bit of wiggle room with a bit of funding, wouldn't that have been able to help GPs? It seems to me that everyone's attention is always on hospitals and yet at the moment GPs, with their funding going down every year, are having real problems.

Jeremy Hunt: I remember the meeting we had, and I particularly enjoyed meeting Dr Bhatti of the Limehouse surgery who talked about those very acute pressures.

Q19 Emily Thornberry: The woman from the Mitchison Road surgery was there as well and she complained.

Jeremy Hunt: Indeed, the one that closed. I am just a bit nervous about the phrase "bail-out", because if you have a surgery that has real challenges, will there be occasions where they need some funding to help them turn the corner and deliver the kind of care that they want to deliver and we want to help them deliver? There may be such occasions and we do that in the NHS.

Q20 Emily Thornberry: Do you mind me interrupting? That is what you call the transformation fund, isn't it? If a GP wants to have additional funding they have to prove that they are transforming their services. But isn't there a problem that if 40% of GPs think that their surgeries are not big enough to provide existing services and 70% believe that their practices are too small to give more, you are asking too much of them, if they want any funding, to prove that they are going to transform themselves?

Jeremy Hunt: That is part of the reason why, as part of the autumn statement last year, we announced that £1 billion of capital funding, which is actually the money that the Government got from the forex fines on banks, was going to be used to help primary care, GP surgeries, modernise their premises. We had a bidding process for the first £250 million of that funding, and there is £750 million more that we will be allocating in due course. We recognise there is a problem with premises. The truth is, as you will be very well aware having talked to GPs in your own constituency, that that is not an instant solution. It takes time to work out, to get planning permission, to get the funding secure and so on and so forth, but we recognise that problem. We also recognise a broader problem—that the balance of incentives in the NHS, as it is now, tends to suck money out of primary care and into hospitals. If you look at the income growth of hospitals over the last Parliament, it was regularly 4%, 5% or 6% a year, quite significant real-terms increases. That was not the case in terms of GP practices. That is essentially because the public benchmark of success in the NHS has been a few targets—the waiting time target and the A&E target—which then puts huge pressure on the system to try and put resources into those areas. Part of the way that we change that is by having a more balanced view of what matters in the NHS and that it is not—

Q21 Emily Thornberry: But if GPs do not have a clear idea about what is going to be expected of them in the next few years, how can they plan—particularly things like investing large amounts of money in premises so that they can have transformative activity—if they do not know what is going to happen from year to year in terms of funding?

Jeremy Hunt: I have tried to address that. One of the first speeches I gave after the election was about a new deal for GPs. I went through all the things that I thought were worrying GPs—the bureaucracy in the contracts, the recruitment of 5,000 more GPs, the involvement of GP surgeries in new models of care—and set in place some work programmes to address those. My intention is that at the end of the year or thereabouts we will write to every GP surgery, post the spending round, so that we can say to people that we now have a settlement with the Treasury, this is the spending profile for the next few years, this is how you can see investment going into general practice and this is how we are going to address those problems. It is not going to happen overnight—I want to be up front about that—but I agree with you that that is a very real pressure point in the NHS.

Emily Thornberry: One hundred and fifty—

Chair: I am very conscious of time, Emily.

Emily Thornberry: I am sorry. I wanted to ask question 4.

Chair: Okay, if you just want to finish on that one.

Q22 Emily Thornberry: This year, £150 million was transferred from the capital budget on top of the £650 million transferred last year. What effect has this transfer had on projects that require capital investment? Presumably it has affected hospitals and GP practices.

Jeremy Hunt: That is a reflection, I am afraid, of the very real operational pressures that we have in the NHS; our commitment to the Government to live within our budget, which was protected in the last Parliament, unlike nearly every other Government Department; and the fact that we had incredible pressure on the front line in terms of people needing treatment, needing to be seen. But certainly in terms of general practice I hope we have been able to mitigate that with the £1 billion fund, which I know has been welcomed by GPs.

Chair: Thank you very much. I am going to come on to a wider discussion about the seven-day NHS, starting with James.

Q23 Dr Davies: There has been a great deal of interest in the concept of a seven-day NHS. Could you outline your latest thinking about this?

Jeremy Hunt: Thank you, Dr Davies. The point about a seven-day NHS is that if you are committed, as I am, to the principle that we want to offer the best care in the world, you look at the causes of some of the problems. Incidentally, I think the founding vision of the NHS in 1948 needs to be as much about excellence as about equity, because in the end giving everyone access to healthcare does not mean anything if they are not accessing the highest quality care, because it means that people with money will then be able to buy high quality care and that undermines the principles of the NHS. If you believe in that principle, as I do, you then have to look at the causes of some of the problems. The weekend effect, as it has become called, is definitely one of those, and we need to do something about it. We also need to recognise that in primary care, which you will be very familiar with, Sunday is the busiest day of the week in A&E departments. Therefore, we need to ask ourselves if that is the right thing for urgent and emergency care. There is a lot of rethinking to be done in terms of the model of hospital care. With primary care it is much harder because of the capacity constraint Ms Thornbury was talking about. We cannot instantly turn on the tap in primary care. We need more GPs, and we must look at new models of care.

The third pillar, if I can put it in that way, is the way that we approach urgent and emergency care more generally. Perhaps I should say urgent care because for emergency care people know to dial 999, but when they have something that is very painful and do not know if it is urgent or if it can wait, the NHS is very confusing at the moment. You do not know whether you should dial 111, go to your local A&E or try to get an appointment with your GP out of hours. It is frankly a very confused offer, and we need to sort it out so that people know exactly what to do. One of the problems with that confused offer is that what you end up doing is known to that bit of the NHS but it is not known anywhere else. We need electronic health records so that wherever you go in the system there is a proper record of what happens to you so that it can be tracked.

Q24 Dr Davies: One of my colleagues will follow on with questions about secondary care, but if I could stick to primary care at this point, how do you see a seven-day NHS

affecting the average GP practice in England, and do you have any indication of the outcome of the pilots that have been ongoing so far?

Jeremy Hunt: Yes. The pilots we have had have been pretty successful. By the end of this financial year, 18 million people will be able to book routine appointments in the evenings and at weekends. We have not said that every practice offering those has to be open at weekends, but they do have to network so that, if it is not your practice that is open, a neighbouring practice is open. It might be that you could use technology such as Skype or good old-fashioned telephone appointments as well; in certain circumstances they could work. This is about responding to the fact that the public now expect a seven-day NHS, but we have to recognise the capacity constraints on GPs and, as Dr Wollaston knows, continuity of care is an incredibly important part of what GPs offer and is another reason why we have to expand the capacity in the system. I want to make sure that we protect that as well.

Q25 Dr Davies: How do these proposals tie in with existing out-of-hours arrangements, and is there potential for further confusion as to where people go when they need, shall we say, urgent care?

Jeremy Hunt: There is definitely that potential if we do not get this policy right. In the same period that we will be delivering our seven-day primary care manifesto promise, we will also be rolling out the urgent and emergency care review being done by Professor Sir Bruce Keogh, which is essentially aimed at simplifying the offer. I cannot tell my constituents very simply what they should do if they are worried about their child's fever at four o'clock on a Sunday afternoon. Essentially, the review is around upgrading the 111 service but making sure that it is linked to out-of-hours care offered by GPs. Things have to be joined up.

Q26 Dr Davies: Would you accept that the main driver in primary care is to relieve the pressure on A&E, and people using incorrect or unsuitable routes to access care, as opposed to simply providing convenience at weekends?

Jeremy Hunt: Obviously that is one of the motivations, but part of the purpose behind our changes to primary care, and the focus that I want on general practice, is to relieve the pressure on general practice as well. I want to create the capacity in the system for GPs to offer real continuity of care, which is the reason, I think, why at heart people most people choose to become a GP—that they can have a relationship with the patient over decades that they cannot do as a hospital doctor. At the moment they do not have the capacity to do that, as they are so rushed off their feet. There are huge amounts of evidence that you reduce hospitalisation if you are seen by a doctor who knows you. That is not to say that everyone is going to be able to see their own doctor every single time, but we need to get that proper continuity of care back into the system.

Q27 Dr Davies: Finally, from the primary care perspective, obviously what you have said will strike a chord with many people—that is certainly fair to say. You have also referred to the fact that there is a shortage of GPs, although there is big pressure on GP numbers. If we are looking at more weekend and evening working, and you have said that overall hours worked will not need to increase, and that there will just be redistribution of hours worked, is

it actually achievable in the near future, bearing in mind that we need to keep capacity up on weekdays as well?

Jeremy Hunt: It is achievable during the course of this Parliament, but it is a much bigger thing than just offering members of the public the chance to book routine evening and weekend appointments. As I said, I think we will have a system where they can do that through networks of surgeries or federations. Indeed, some GPs may choose to offer that by recruiting extra help to offer those services, so that they do not themselves work in the evenings and at weekends. The real point here, relating back to our earlier discussion, is that potentially around 20% of the £22 billion of savings that we need to find in the NHS in England will come through new models of care, where we catch illnesses earlier and stop people needing to go into hospital, because we are nipping things in the bud. That means backing GPs to do what they do better than anyone else. It is giving them the ability to restore the sense of vocation in what they do—what the head of the BMA GP committee talks about as restoring the magic of general practice. That is what we need to do. It is going to be a big job to get there, but I know we can do it.

Dr Davies: Thank you.

Q28 Dr Whitford: I am going to speak mostly about hospitals, but just to pick up on the end of the primary care questions, is it not the case that some of the pilots have been abandoned because the uptake on a Saturday was only 50% and on a Sunday only 12%? In Scotland, all surgeries had either to open early or stay late. My husband's surgery opens at half-past 7, and it is pensioners, because in actual fact the demand from fit, healthy working people is not enormous. Is it not going to be the case that a GP would rather sit reading the paper in a very quiet Sunday surgery instead of going and slogging at out of hours?

Jeremy Hunt: There have equally been pilots, such as the surgery that I visited in Bolton, where weekend appointments were spectacularly successful. Obviously we need to match the availability of appointments at evenings and weekends with the demand. There are a lot of working people who do not want to have to take time off work to see their GP, and we need to understand and respect those needs. What you are talking about is a very good reason why we do not want to have a completely inflexible approach, where we are paying for GPs to sit reading the papers, as you say, when their services are not needed. That is why it is really important that we set up flexible arrangements that respond to the public demand but are a good use of resources.

Q29 Dr Whitford: That is quite good to hear, because what we heard was eight till eight, seven days, and looking at the variety of general practices, there would be lots of places where that was not at all appropriate.

Jeremy Hunt: Just to clarify, we are not saying that every practice has to be open eight till eight, seven days a week. We are saying that every practice needs to offer its patients the opportunity to have routine appointments eight till eight and over weekends, but that might be at a neighbouring practice, by Skype or through some federated arrangement. I am sure the demand overall will be less, and that is why we need to match the supply with the demand.

Q30 Dr Whitford: Obviously you will need to take care in rural areas because even sharing in a rural area could be quite destructive and just not deliverable. It is important that there is not just a pronouncement that everyone has to meet in every part of the country, and that it is to meet the local demand.

Moving to hospitals, you mentioned in your earlier answer the problem of theatres being wound down and then cranked up. Is it therefore your suggestion that in hospitals operating theatres should all be running seven days a week and, if so, for what—for routine work?

Jeremy Hunt: That is something we have to leave to hospitals themselves to work out. It would not be sensible for me as Secretary of State to prescribe across the whole country the hours that operating theatres work. I just make the observation that there is an inherent inefficiency in the system that we have which has a direct effect on patient care. My priority in this policy is the reduction of excess deaths because of the weekend effect. In Scotland, you have managed to eliminate excess deaths at the Royal Infirmary of Edinburgh; I think readmission rates were reduced by 4%. We have had good success at Northumbria and Salford. Those are really good models of safe care for patients, and that is the objective of this policy.

Q31 Dr Whitford: The important thing in that, though, comes back to James's question: what is the aim of seven-day working? We have drifted again on to convenience and access for people who are working, but if the aim is tackling the excess deaths—particularly when we have no money—should we not be focusing on trying to tackle people who are ill?

Jeremy Hunt: Correct, and that is the purpose of our seven-day hospital policy; it is squarely focused on the elimination of that weekend effect, those excess deaths. We have had a big public debate about this over the last few months. It is very important to say that this is not just about the consultant contract. That is part of it, but it is also about seven-day diagnostics, which are very important. If you are a consultant working at the weekends you need to get those test results back quickly. It is about handovers; it is about the way ward rounds are done and the speed at which people are seen by a senior consultant when they are admitted at weekends. There are lots of different factors in that. When it comes to transforming primary care, that is the whole purpose behind the Five Year Forward View, the NHS in England plan for transforming services. Increasing convenience for the general public in terms of being able to make routine evening and weekend appointments is a manifesto commitment that this Government made so we have to honour that, but it is part of a much bigger strategy, which is a dramatic increase in the capacity of general practice and the capacity of primary care so that we make the most of the crown jewel of the NHS, our tradition of primary care, which many countries do not have but in which we have under-invested for decades, leading to huge amounts of stress and burn-out in general practice. We are mad if we do not, first, see that that is a problem and, secondly, do something about it.

Q32 Dr Whitford: Coming back to seven-day working in hospitals, you talked about excess deaths, and previously you talked about avoidable deaths at weekends, but we do not have evidence that these are avoidable deaths. As Bruce Keogh pointed out, they are, statistically, excess deaths. The problem is that if you look at exactly the same paper by

Professor Freemantle it is important to understand that we did not have any extra deaths that occurred at the weekend; it is deaths in people who were admitted at a weekend, so the death might have been 29 days later. Unfortunately, the impression has been given that there is just nobody there, the place is like the Mary Celeste and therefore people are dying. Surely it is much more complicated.

Jeremy Hunt: It is, and you are absolutely correct to say that. The issue is not about people who were admitted earlier in the week and happen to be in hospital at the weekend, because they tend to be stabilised and looked after very well. It is people who are admitted at the weekend who do not get expert consultant advice as quickly as they need. We know, for example, that if you break a hip and need to have an emergency replacement, your chance of dying is significantly reduced if the replacement is done within 48 hours. But if you are admitted at a weekend, the chance of that happening goes down by 24%. If you have a stroke, we know that in London we are saving around 96 lives a year because we reduced the number of hospitals doing stroke care from 30 to eight, and they are all 24/7 units and that has led to a significant increase in the lives saved as a result. We know that it has a very significant impact, and that is why it is the right policy to pursue.

Q33 Dr Whitford: To pick up on the issue of strokes, which obviously showed up very much in Professor Freemantle's paper, with a very powerful weekend effect, if you look at Bray's research on whether the change should be seven-days-a-week consultant ward rounds or a better ratio of registered, qualified nurses to patients, it was not the consultants that made the difference—it was the nurses.

Jeremy Hunt: Professor Sir Bruce Keogh, who has done a huge amount of pioneering work in this field, published four standards which he thinks are the most critical in terms of—

Q34 Dr Whitford: We are going to touch on the standards. I have seen them and I would not dispute any of the standards.

Jeremy Hunt: But those standards specifically say that one of the absolutely critical factors is the speed with which you are seen by a consultant if you are admitted at weekends. The availability of consultants at weekends is very important in terms of—

Q35 Dr Whitford: Are you implying that in an emergency service receiving stroke patients, or in any kind of an emergency, there would not be a consultant involved in that service—that it would just be junior doctors and no consultant?

Jeremy Hunt: The honest answer is that it is patchy. We have half as many consultants in our A&E departments at weekends as we do in the week, and Sunday is the busiest day in our A&E departments. If you ask hospitals what the biggest barrier to eliminating that weekend effect is, they say the availability of consultants is their biggest concern. But it is very important to say that it is not the only concern; other things need to happen if we are going to do this, as we can see from the trusts that have been successful in doing this—things like making sure that you have seven-day diagnostic services, that you have proper handovers at the weekends if people are being moved back to the community and so on and so forth. There is a big group of policy measures that need to be implemented.

Q36 Dr Whitford: I understand, of course, the complexity of it, but do you not think that we are rushing in and wanting to change the contract when we do not quite know exactly what is causing the effect and what the solution is? We know that elective patients who are admitted on a Sunday are more ill, otherwise they would not be allowed to be admitted on a Sunday; so we have a sicker cohort of patients. Mid Staffs was not particularly blamed on lack of consultants; it came down to nurses and trained nurses being reduced. Bray reviewed 103 stroke units—it is not a little paper—and suggested the big change was from having a high proportion of nurses to patient and a high proportion of qualified nurses. Do we not need to be absolutely certain where the investment should go before you make it?

Jeremy Hunt: We do, and I follow the advice of my own NHS England medical director who is clear about what the key factors are. You mentioned Mid Staffs. The tragic death of John Moore-Robinson happened because he went to an A&E department on a Sunday, and he had a ruptured spleen which was not spotted. He was sent home and subsequently died. If you talk to the families who lost children tragically at Morecambe Bay, a number of them say that their tragedy happened at a weekend. There is a lot of evidence of tragedies that happen at weekends. We can only look at what the clinical evidence is and the many studies that have been done. With the greatest respect, this is not something that I have rushed into. We have been trying to negotiate these changes in the contract for two and a half years, and the BMA have refused to talk to us.

Q37 Dr Whitford: Do you actually need to change the contract to do the changes?

Chair: I am very conscious of time.

Dr Whitford: In Scotland these changes, like having access to diagnostics—to scans—have been evolving over the last 10 years and the Scottish Government have been very much working with medics, so do you actually need to change the contract? The opt-out that you mentioned is to do with routine work and has been signed by 1% of doctors. Surely the contract does not need to change to beef up and focus our energies on the weekend.

Jeremy Hunt: The advice that I get from the people who run hospitals is that the opt-out in the contract is the single thing that makes it difficult for them to deliver truly seven-day care. It is true that the opt-out is for non-emergency care. It is also true that we have half as many doctors in A&E at weekends as we do during the week, that if you need emergency bowel surgery after midnight the number of operations where there is a consultant and an anaesthetist present goes down by 41%. They say that that opt-out has created a culture where it is difficult to deliver seven-day care. What often happens at the moment is that because they want to do the right thing they negotiate with consultants who have opted out for them to come in at the weekend, but they have to pay very high rates to do so because it is an off-contract request and there is no obligation on the consultants to do that. The result is that it becomes very expensive and therefore de facto it becomes something they find very difficult to do. It is important to say this is not the only thing that will deliver seven-day care, but it is an important thing that we need to do.

Q38 Dr Whitford: Yet figures show that 90% of consultants do nights and weekends, and only 1% have signed an opt-out clause against doing routine work. I just do not see where the barrier should be if the discussion is had. No doctor or nurse, or any

clinician, wants to see people dying in their unit. Could it not be done through discussion rather than changing the contract?

Jeremy Hunt: We have tried to have those discussions; we tried very patiently over two and a half years. Pretty much from when I started as Health Secretary, we tried to have those discussions and we were met with, essentially, a blank wall. In the end, we had to take a decision as to whether we were going to change this or not. I know how hard doctors work, and I know that many of them work at weekends. The truth is, though, that it is not a normal part of our culture; the NHS does not offer the same standards of safety and care at weekends as it does mid-week and that leads to these excess deaths. That is what I am determined to change. It is one of a number of factors, but I am absolutely clear, as Health Secretary, that it is not acceptable to offer substandard safety in our hospitals at weekends. I want to do something about it.

Q39 Dr Whitford: That would be your focus—the emergency side and not routine.

Jeremy Hunt: Correct.

Dr Whitford: Thank you.

Q40 Maggie Throup: You have already touched on the fact that seven-day working is not just about consultant contracts and extra GPs; it is also about diagnostic services. Will other workforces, such as pathology and radiology, need to expand to provide that seven-day cover?

Jeremy Hunt: It is highly likely that they will. One of the fallacies in the debate that we have been having about seven-day care is that we are seeking to take the care that we currently give and, instead of concentrating it on five days, spread it evenly over seven days. That is actually not what is going to happen, because with 1 million more over-70s, as we talked about before, with the amount of care we are going to give and the volume of operations—we are doing about 1.3 million more operations every year than we were five years ago, and that will increase potentially by the same amount again—we will need extra pathologists, people working in laboratories, going forward, and we will need to make sure that the service they give is a seven-day service.

Q41 Maggie Throup: Are plans in place for the recruitment and training of such staff?

Jeremy Hunt: We are putting in place plans, and we will be announcing in due course—fairly soon actually—what those plans are, but as a taster of the kind of thing we are trying to do I announced last week our plans on cancer, making a promise to NHS patients that we will give them either a diagnosis or the all-clear within 28 days. That will need around 200 more nurse endoscopists and around 250 more cancer consultants. In different areas, we are starting to make those decisions.

Q42 Maggie Throup: You also mentioned that seven-day working is not just about spreading five days out across seven days. How will it be possible to improve weekend and evening services without negatively impacting on routine care?

Jeremy Hunt: Because we will be recruiting more doctors to help us deliver this service. In the last Parliament the number of doctors went up by about 9,000. I cannot give a

projection as to what is going to happen, but I am pretty certain that we will see an increase of around the same, if not more, during this Parliament because of the extra demands the NHS faces. That means that, as we start to offer weekend care, we will have more capacity to do it.

Emily Thornberry: May I ask a quick question?

Chair: Hold on. We have quite a few to get through.

Q43 Maggie Throup: Obviously it will all cost a lot of money. What estimates have you made of the total cost of introducing seven-day care—seven-day working, I should say?

Jeremy Hunt: Indeed; seven-day services actually. It is very important for doctors that this is not saying you have to work seven days; this is about spreading the care that we give to patients over seven days on an equal basis for urgent and emergency care. We think that there may be some up-front costs in rolling it out, of the order of hundreds of millions of pounds rather than billions of pounds, but we also think we may recoup some of those costs because of the increased efficiency of safer patient care. Those numbers are what we are working through now as we discuss the spending review with the Treasury. This is a clear manifesto commitment we made, so we have to deliver it and make sure that it is appropriately costed in whatever settlement we end up with.

Q44 Maggie Throup: I always think the NHS works in silos; I have been very conscious of that for many years. How can you break down those silos so that savings made in one place can be invested in other places?

Jeremy Hunt: We could have a whole Select Committee session just on the issue of how we break down the silos inside the NHS and between the NHS and the social care system, but the answer is that we need to change the way that we commission services in the NHS to a population-based commissioning model based on capitation fees rather than the payment-by-results system that we have had for a long time. That is something which will be a very big change. I know that a number of CCGs are moving towards those systems, and the reforms and new structures that we have post the 2012 Act make that possible.

Q45 Maggie Throup: Do the estimates that you are making include the extra costs of the diagnostic services?

Jeremy Hunt: The estimates we are making will include all the costs of moving to seven-day services.

Q46 Maggie Throup: This is my final question. I was reading a report by the Royal College of Surgeons recently that suggested that delivering seven-day care will require centralisation of hospital services, and perhaps further organisational changes within the NHS. Are they right?

Jeremy Hunt: They are right for particular services. It is not the case that when we announce our plan every single hospital will be offering the full suite of seven-day services for all urgent and emergency care. There will be networking arrangements, and the plan is essentially that it would be either your local hospital or a nearby hospital, and that we would have the systems in place to make sure you get to the place you need to get

to, subject to what your care requirements are, so that patients are always able to access seven-day care. Patients are much more willing than they have been in the past to travel when they recognise that they will get better services at the end. We talked about stroke services in London. London is the safest place in the country to have a stroke now, but people in London will not typically go to their nearest hospital if they have a stroke in the middle of the night; they will go to a hyper-acute stroke unit that will have the right people on call 24/7. Those are the kind of details in the plans that we will be announcing.

Q47 Maggie Throup: Also, as James alluded to earlier, there is the fact that people do not know where to go. Isn't that going to be the same for secondary care as it is for primary care at the moment?

Jeremy Hunt: Yes, and that is why we are doing the urgent and emergency care review—to introduce that simplicity so that people know exactly what they need to do, and indeed simplicity so that they know wherever they go in the NHS someone will be able to access their medical record. Every year, 137 people die or are seriously harmed because of a medication error, and that is sometimes because they are being given medicine by a professional who does not know what their allergies are and does not know their medical history. Obviously with smart use of IT, and with all the protections in place, we can avoid that.

Chair: Thank you. I am going to move on to the next group of questions around workforce. Paula is going to lead on that.

Q48 Paula Sherriff: Thank you for joining us today, Secretary of State. I would like to talk about agency staffing costs initially. It has been very well publicised, particularly recently, that agency costs have risen by £1.5 billion over three years. Before we look at how we practically reduce the bill, I am quite keen to gauge your views on how we reached the unprecedented increase. Could you initially comment on why you think there has been a 29% increase in the number of nurses leaving the profession—I think during the same period as the increase alludes to—and also whether you think the rise in agency costs was as a consequence of the number of nurse training places being cut in the last Parliament?

Jeremy Hunt: I will unpack that and take them all one by one, if I may. First of all, why did it happen? I think it happened because the NHS wanted to do the right thing. We had Mid Staffs. There was a clear issue about short-staffing, and the NHS collectively decided they did not want that to happen. The NHS was extremely honest about the fact that the problems in Mid Staffs were not just problems in one isolated hospital; people recognised that there were pockets of this happening everywhere and short-staffed wards was one of the problems. In the immediate period after the Francis report 8,000 more hospital nurses were employed; over the last Parliament as a whole, it was around 9,000 more full-time nurses. That is before the increase in agency nurses as well. We had a big increase in the nursing workforce over that period, and I think that was welcomed by a lot of nurses working on the wards, who felt they had more support to deliver the kind of care that they want to deliver. Hospitals reacted to that. I was partly driving that because I introduced a new Ofsted-style inspection regime very much focused on quality, recognising the importance of targets but saying it is not just that—it is also about the quality of care that is being delivered. Because of that new CQC inspection regime, again hospitals reacted by wanting to make sure that they had enough staff on their wards. In the short term, if you

want to increase the number of nurses very quickly, obviously an agency is the easiest way do it, but the truth is that it has gone much too far and we have a situation now where trusts are hiring agency staff not for an unexpected surge in demand but just to meet their daily pressure. We have some trusts where 35% of the staffing budget goes on agency staffing, and the rates are that you can have a nurse paid £2,000 for one ward, a doctor paid £3,500 for one shift. It is completely unsustainable. It is also very divisive for staff.

Paula Sherriff: Absolutely, yes.

Jeremy Hunt: You have some staff who are working as full-time professionals in a trust and then you might have another member of staff who says, "I am going to work 24 hours as my full-time contract but I am going to do 12 hours a week with an agency," and ends up going back to the same trust as an agency worker and getting higher pay. That is not fair on staff. We have to end it and that is why we introduced some controls, working very closely with David Williams, the new finance director. We said that from 1 October there is a cap on the percentage of every trust's pay that can go to agency staff. From 19 October, trusts will all pay framework rates, which are sort of standardised national rates, rather than off-framework rates that can be very expensive.

Q49 Paula Sherriff: Why do you think we have seen such a significant increase—a 29% increase—in the number of nurses leaving the profession in the last three years or so?

Jeremy Hunt: I am not quite sure where those numbers have come from—I have not seen them before—but the backdrop is an increase in full-time nurses in the NHS. I think we now have more nurses in the NHS than we have ever had, or if not we are nearly at record levels.

Q50 Paula Sherriff: Can I confirm that in terms of the total numbers of nurses in the NHS across the country it seems to be quite unevenly distributed? In Yorkshire and Humber, which is obviously a very large region geographically, as I understand it, we are down from what we had and, unfortunately, we appear to be one of the poorer relations in that region in terms of nursing numbers. Sorry, I am digressing slightly, but what are you doing to maintain a balance, because obviously the fewer nurses we have the more we are going to have to rely on agency spend?

Jeremy Hunt: Obviously I do not directly control the number of nurses hired by trusts. I control the climate in which they operate, and the climate that I am trying to set is one that says that, first of all, I want you to deliver the highest standards of care because that has to be our unifying ambition in the NHS, and, secondly, the highest standards of care are not generally delivered by agency nurses. There are some very committed agency nurses, and I would never disparage any individual, but continuity of care matters. Agency nurses are effectively like temps. They could be working somewhere completely different the next day and you may never see them again, whereas full-time nurses become part of a team, have loyalty to the institution, get to know the patients and are therefore able to offer better care.

Q51 Paula Sherriff: Thank you. You have just answered one of my follow-up questions. Can you tell us what savings NHS trusts can collectively expect to make as a result of introducing a cap on agency staffing costs within the first year of implementation?

Jeremy Hunt: £350 million.

Q52 Paula Sherriff: What assessment have you made of the impact the ceiling on agency spend will have on nursing staffing levels?

Jeremy Hunt: I might ask David Williams, the finance director, to confirm this, but I suspect the impact will be an increase in the number of full-time nurses, as people wean themselves off the habit of hiring agency nurses. But it will be a difficult transition.

Q53 Paula Sherriff: I agree that that would be the optimal result, but I would like to see the process as to how it is going to be achieved.

Jeremy Hunt: Would you like me to ask David Williams to come in?

Q54 Paula Sherriff: That could be sent to us at a later date, if that is okay. Before I go on to my final two questions, the 29% figure is from the Carter interim report—I do not know if that is something you are familiar with—which you might want to take a look at.

Obviously at the moment we are reliant upon a large number of nurses from other countries, and the proposals to increase the nursing workforce that you have just alluded to will not come to fruition in the short term. Spending on agency nurses is going to be capped and the immigration system rejects nurses from outside the EU. How do you suggest that trusts recruit sufficient numbers of nurses in light of those constraints?

Jeremy Hunt: First, the NHS has a fantastic number of nurses from abroad who do a brilliant job; large parts of the NHS and care system would fall over without the brilliant care that they deliver and I think we should acknowledge that. The second point is that we are now finalising the nurse training places for this Parliament. At the start of the last Parliament, my predecessor—in fairness to him, because it was before the Francis report into Mid Staffs—did not know there was going to be, as a result of the Francis report, a big increase towards the end of the Parliament in the number of nurses required. We have increased nurse training places back to near record levels, but we need to make sure that for this Parliament we get a better picture of the nursing levels that are going to be required towards the end of the Parliament. What do we do in the interim period? It is still possible to recruit nurses from abroad and we are still issuing visas for nurses to come here, but it is also important for trusts to look at their rostering practice. You talked about the increase in nurses who are leaving the profession. One thing I would ask is whether one of the reasons nurses leave is that the work they are offered is not flexible, and they are not given as much choice as they might be over the hours and shifts that they work. We can do a lot more work across the NHS in terms of making sure we retain people better by offering them more flexibility; GP recruitment is another area.

Q55 Paula Sherriff: Having worked in the NHS for such a long time, I think morale is a huge issue, but I am conscious that one of my other colleagues will come to that in a moment.

A final question from me is whether you have discussed this problem with colleagues across Government, which I am sure you have, and do you expect the rules to be amended so that trusts can recruit full-time nurses permanently from outside the EU?

Jeremy Hunt: They can recruit full-time nurses from outside the EU and we issue visas. We have an ongoing dialogue with the Home Office to make sure that the number of visas being issued is appropriate for the needs of the NHS.

Paula Sherriff: Thank you.

Q56 Rachael Maskell: What do you see as the role of an independent pay review body?

Jeremy Hunt: An independent pay review body—I think I know where these questions are going, by the way—does what it says on the tin. It is independent, it looks at very difficult pay issues and it gives its independent advice to the Government for the Government to look at.

Q57 Rachael Maskell: I have been before the pay review body and I know there is some real expertise that sits there, including economists who look at the condition of NHS pay. Over the last five years, NHS staff pensions have been cut, and their pay in real terms reduced by 15%, and for some it is even greater due to down-banding and removal of allowances. Obviously we know that you have pronounced again a 1% pay increase. How do you think that is going to impact on morale?

Jeremy Hunt: Morale is not good in the NHS at the moment. It is very tough on the front line. People are working very hard, and I want to do everything I can to provide leadership to the NHS, going through a very difficult patch—one of the most difficult periods in its history—but I think we are facing up to the challenges that we have. There is no bigger commitment than the Government's commitment to the NHS. Sitting at the middle of all of that is the very thorny question of pay. My perspective on pay is that I would like to be as generous as I possibly can with pay, but I would never go so far that it meant that NHS providers had to lay off nurses. Having been through the whole Mid Staffs thing, having seen the problems that you get from short-staffed wards, I do not want to make a decision and impose from the centre a pay award that someone running a hospital—where, as we said before, three quarters of their budget is spent on pay—cannot afford, and they are left with no choice but to lay off staff. It is worth saying that on top of the 1%, around half of NHS staff get an average of 3% extra pay through increments, so it is not only the 1%.

Q58 Rachael Maskell: That is not quite true. The majority of people have now reached the top of their band because of staff limitation and people not moving on, and increments average from 2.4% to 2.5%, so it is not 3%. It is important to get the facts right.

Jeremy Hunt: Okay. I said around 3%, but if it is around 2.4% or 2.5% my point is that there are a lot of NHS staff who are getting a rise in their pay on top of the basic pay award. The point I really wanted to make is that an extra 1% costs the NHS £450 million, which is around 14,000 qualified professionals. If I get the calculation wrong in terms of the pay award that I give, it can have a very dramatic impact on patient care. The discussions that I have with nurses are, yes, they want and deserve a decent pay rise, as everyone does, but most of the discussions are about making sure they have enough people working alongside them to deliver the care that they want to give patients. I have to balance those two objectives, and I accept that it is a very difficult thing to get right.

Q59 Rachael Maskell: First, I want to pick you up, because it is not just nurses. There are hundreds of professions in the NHS.

Jeremy Hunt: I agree.

Q60 Rachael Maskell: It is important that we do not just hear about doctors and nurses. I also want to pick you up on the issue of increments. Increments are awarded under the knowledge and skills framework for increased knowledge and skill, and, as you know, that has never been just about automaticity—an issue in itself—so you are getting more skilled knowledge applied as a result of a small reward. It is a false choice that I believe you have presented to the Committee today about laying off more staff and increasing pay, because one of the other things you have emphasised in today's session is increasing productivity. As I stood on the picket line with staff last January over the pay dispute—which I do not believe needed to go ahead had we had negotiations—they were saying they went to a food bank; they had worked in the NHS all their life, but they could not survive; they felt "kicked in the stomach"—the phrase that they used—for all of their labour. We must remind ourselves that so many people now give around—from my previous membership of Unite—eight hours' unpaid overtime every single week. How are you going to balance productivity and wanting more and more out of staff at the same time as cutting real-terms pay or this kind of offer of 1%? To add one point of clarity, is 1% including the increase in the new minimum wage or is it going to be in addition?

Jeremy Hunt: I do not accept that we are cutting real-terms pay. We are increasing it, and the pay bill is going up. That is why, if we are going to be able to afford pay rises, we need productivity improvements as well. I am trying to deal with the huge pressures on the NHS that mean that we need more staff to deliver the high standards of care that everyone wants to deliver, and with the completely understandable desire of everyone working in the NHS to have a decent pay rise to recognise those efforts. I recognise that there is a lot of unpaid work that happens, but I would challenge you in saying that there is not a choice between being more generous on pay and staff. Hospitals have a pay bill. They know they have to live within the budgets they have and they are very straightforward about this. If they have a national pay award that is beyond what they can afford to deliver, they will have no choice but to lay off staff.

Q61 Rachael Maskell: But that is about choices.

Jeremy Hunt: It is about choices.

Rachael Maskell: No, I mean the choice of the budget you provide them.

Jeremy Hunt: Yes, it is, of course.

Rachael Maskell: Absolutely.

Jeremy Hunt: A very important choice we make as a Government is how much money to put into the NHS nationally. The choice we made was to protect and increase the NHS budget in real terms in the last Parliament, unlike other Government Departments where, with only one or two exceptions, it was cut. We made a very big choice—it is the second biggest budget in Government—to protect it, and in this Parliament we have gone further by putting an extra £10 billion in real terms into the NHS during the course of this Parliament. Yes, we have made those choices, but the point I would make is that the

reason we cannot go further is that we have looked at what has happened around the world and we believe that in the long run, if we do not tackle our deficit, we will not be able to invest, and continue to invest more in real terms, in the NHS. In countries that have not tackled their deficit, they have ended up cutting their health budget, not increasing it. We have increased it in this country and we want to carry on increasing it, but that means we have to live within the Government's overall deficit reduction plans.

Q62 Rachael Maskell: I have a final question, if I may. The NHS staff survey shows an increase in stress among staff—clearly they are having to be stretched further—and a drop in morale. Therefore, in your bid to the Comprehensive Spending Review did you talk about the issue of increasing staff pay?

Jeremy Hunt: We have absolutely talked about making sure that we are able to continue to increase staff pay. The importance of retaining good staff in the NHS was also in the Five Year Forward View. We recognise the stress that people are facing at the moment, but I think that stress is also caused by not having enough staff to deliver the kind of safe care that we all want the NHS to be able to deliver. I have to make sure that I balance the need for more staff with the desire to give people a fair pay rise.

Q63 Helen Whately: I have a question on the point about staff morale in the NHS. The NHS is only as good as its staff. As you said earlier, and we have been discussing, morale is not good. One thing that particularly alarmed me in the last NHS staff survey was that only 41% of staff felt that their trusts valued their work. The CQC is picking up bullying and a culture of fear in some hospitals as they do their inspections. Earlier you said that you want to do everything you can about the morale problems within the NHS. Could you be more specific about what that actually means—what that will involve?

Jeremy Hunt: Yes. That is not the only thing that is troubling in the staff survey. We have bullying rates in the staff survey that are shockingly high; a figure of 22% springs to mind. There is very clear evidence that the trusts, hospitals and GP surgeries that deliver the best care are places where staff morale is high. The CQC will say that happy staff equals happy patients, so that is why supporting staff is really important. That is why these are very difficult issues when we have very tight constraints on finances, but what can we do? The first thing we can do is make sure that there is a good plan for the future, that staff feel that there is an exciting plan to transform services so that we can cope better with some of the pressures that we have. Secondly, they should feel there is a Government that is backing that plan, and putting the money into that plan that it needs. Thirdly, we need to look at the culture inside the NHS so that staff feel better supported. We have done a lot of work with Helene Donnelly, a nurse at Mid Staffs who was bullied when she was working in the A&E department, spoke out and in the end nearly lost her job as a result. She is now working to transform culture across the NHS. We need a culture where staff feel they are listened to and supported, and that they can talk openly when something goes wrong so that lessons can be learned. If we want to deliver the safest and highest quality care in the world, we need to support people who want to speak out. There are lots of different things that we need to do; none of them is easy and none is going to happen overnight, but they have to be a very important part of our plans for the future.

Q64 Helen Whately: I particularly picked up on you talking about the importance of looking at the culture inside the NHS, and absolutely that is important, but what about the particular thing about staff feeling valued? Is anything going on to look into that?

Jeremy Hunt: Yes, that was the entire purpose of asking Robert Francis to do the "Freedom to speak up?" review, which he has just completed, to make sure that staff feel supported. It is interesting that we often look now in the NHS at the airline industry, which halved the amount of airline fatalities over, I think, a 30-year period, at the same time as air travel was increasing dramatically, because they changed the culture, particularly among pilots, to make it easier, and make pilots feel more supported, to speak out. They realised that unless they encouraged pilots to speak out about near misses, safety breaches and things that were worrying them, they would not be able to get to the bottom of how to change things to prevent those things happening. That is why Sir Bruce Keogh is looking at professional codes to see whether anything needs to be changed there, and what we can do to support staff to create that learning culture, which I think will make a big difference.

Q65 Helen Whately: To me, that is very much focusing on the speaking-up agenda and whistleblowing, openness and candour, all of which I support, but there is a distinction between that and the point about staff feeling valued by their organisations and by the NHS.

Jeremy Hunt: It is part of it. Part of it is for staff to feel that they have management who care how they feel and care about what they are doing, and I do not think it is different. Basildon, for example, is a trust that was in special measures, and under the inspiring leadership of Clare Panniker, it has turned round and is now a CQC good-rated hospital. I spoke to a nurse in the paediatric department and asked what the difference is now under the new leadership and she said, "Before when I had a problem they weren't interested"—"they" being the management. "Now when I have a concern they listen." As a result, the staff at Basildon feel valued in a way that they did not feel valued before. That is why I think it is a very important part of that culture change.

Q66 Andrea Jenkyns: If I can come in on this point, I agree that feeling valued is obviously an important factor, but isn't feeling valued also about local leadership? In my management career, it was about people on the ground, leaders on the ground, who actually value their team and move forward with it. Is anything being done at local leadership level, at trust level, to really push that kind of agenda?

Jeremy Hunt: Yes, it is. The new CQC inspection regime has five domains, of which safety and patient experience, or clinical effectiveness, are some, but leadership is one of their key domains. The other thing that is really interesting is that the hospitals getting good ratings from the CQC seem to have a certain type of leader, not necessarily the leaders that were put on the pedestal by the NHS before, but people like Clare Panniker at Basildon and Tracey Fletcher at the Homerton or David Dalton at Salford. These are people who are good listeners and who the staff respect because they think this is someone who, like them, is putting patients first and values their efforts to do so.

Q67 Andrew Percy: Is there any evidence that the inspection regime has had any impact on morale? You keep mentioning Ofsted. I was a school teacher before I came here, and the Ofsted regime is a regime that initially people thought was being done to them—it probably still is in the profession—rather than being something to assist. I thought the Ofsted

regime was there to help us because we all wanted the same thing—to improve outcomes for pupils. It is the same in hospitals. When I talk to local nurses, and ambulance staff as well, the thing they say to me is that they feel that all this added inspection and burden on them is being done to them rather than for their benefit, and almost to catch them out. Has any work been done on whether or not there has been an impact?

Jeremy Hunt: We have looked at the Ofsted regime and tried to learn from it. The purpose of both the Ofsted regime and the CQC inspection regime that we have in the NHS is to turn the NHS into a learning organisation. It is not like giving you your A-level results and saying, "This is the verdict on your years of education." It is saying, "This is where you are on the quality ladder. This is what you would need to do to get higher on that ladder." It is designed to give people constructive support and advice. It is interesting how this relates to the morale issue, because the picture on morale in the NHS is not uniform. There are places in the NHS where morale has improved dramatically over the last three years. I would cite as examples of that the trusts that have been in special measures and have been turned round. Your own trust is a good example of that, and Lincoln hospital, not so far away, is another example of a trust where morale has been transformed. Tameside is another hospital which has come out of special measures. What happens when a trust gets a bad CQC inspection and is put into special measures is, of course, that there is initially a dip in morale, but then they see things happening, things that they wanted to happen for years and years. They see that change. They see more nurses and doctors being hired, they see a different style of management coming in and morale shoots up. I have had some nurses in those hospitals saying that it has never been higher, sometimes even before they have left special measures, because they can see those changes happening. The true picture when it comes to morale in the NHS is that, if people feel their organisation is on a journey that is improving the care that they give patients, morale improves. We need to make sure that more and more places feel that sense of mission, which is part of the driving force why people become doctors and nurses in the first place.

Chair: Thank you. We are going to move on to the next area, which is public health and prevention. Andrea is going to lead on that.

Q68 Andrea Jenkyns: Secretary of State, you spoke earlier about trail-blazing across the world, which I am sure most of us here would support. One area where we can do this is prevention. Already we have our Five Year Forward View, and prevention is an important factor. We would like to understand how the decision to cut public health budgets this year by 6.2% fits with the call in the NHS Five Year Forward View for a "radical upgrade" in prevention and public health.

Jeremy Hunt: The answer is that when budgets are very tight we sometimes have to cut budgets, but we are asking the whole NHS to make efficiency savings, and that includes the public health side of things as well. The £22 billion of savings is probably an efficiency saving of around 15%, and we need to ask the public health part of the budget to make savings as well, but that does not mean that we need to accept that we will have less good public health outcomes. In fact today we have had good news on the public health front: we have seen that our life expectancy has gone up over the last 20 years to 79 for men and 83 for women. For men it has now overtaken Canada, Norway, the Netherlands and France, and for women it has overtaken most major European countries except Germany. We are making, I think, some progress, but we need to make sure when we are having to make difficult budget decisions that it does not affect that great progress.

Q69 Andrea Jenkyns: Future-proofing our NHS is obviously the key. What assessment have you made about the likely impact of the one-in, two-out principle on proposals to regulate and improve public health?

Jeremy Hunt: It is quite possible to have one-in, two-out in a way that still allows us to have new regulations that improve public health. If you look at the last Parliament, where we had a one-in, one-out principle, we were still able to introduce new regulations; from 1 October, coming up in a few weeks' time, we will be banning smoking in cars, banning the sale of e-cigarettes to people under the age of 18, and making some very important measures with respect to proxy purchasing of tobacco. It is perfectly possible to find regulations that we can dispense with at the same time as introducing important new ones that we need.

Q70 Andrea Jenkyns: Can you give a broad outline for your plans for tackling childhood obesity? As somebody who has worked in education as well, the whole agenda of education on sugar is important. What are your plans regarding this?

Jeremy Hunt: This is a commitment that we made, and we will shortly announce our plans on obesity—a very big priority for the Parliament—I hope before the end of the year, but suffice it to say that we need to do a lot more than we are doing at the moment. It is completely unacceptable that one in 10 children enters primary school clinically obese and one in five children leaves primary school clinically obese. We know that it has a direct impact on health and life chances in all sorts of ways, but it is not something that the Department of Health can do on its own. It needs to be a joined-up approach with the Department for Education, with local government and with the Troubled Families programme, because there is a direct link between obesity and social deprivation. We are pulling together our plans at the moment, but it is a big priority.

Andrea Jenkyns: Thank you.

Q71 Chair: Could I follow up a couple of the earlier points? Do you think it is correct to say that the public health grant is non-NHS front-line services? It includes things like school nursing, screening programmes, drug and alcohol services, smoking cessation, sexual health clinics, and more things are being added to it. Are you concerned that these are cuts in-year in budget when a lot of those funds have already been committed?

Jeremy Hunt: Around 40% of the public health budget is spent on treatment services, helping to maintain our reducing rates of drug addiction, alcohol addiction, smoking cessation and so on, and the rest of it is spent on the prevention agenda. You are absolutely right; when we look at that budget, we have to be very careful to make sure that what we are asking for is a genuine efficiency saving and not something that is going to impact on the delivery of services and undermine what we all want, which is a healthcare system that is moving to prevention and not cure as the basis on which we operate.

Q72 Chair: Do you recognise the concern across directors of public health that this will result in changes to front-line services that will impact not only on care now but on the Five Year Forward View agenda of trying to save money going forward, as you yourself have

alluded to, making sure we do not make changes that make things worse down the line? Does it worry you?

Jeremy Hunt: Of course I recognise those concerns. They are entirely understandable, but it is important to say to the public health community, who I am going to be speaking to tomorrow at the PHE conference, that just as the NHS in the delivery of its core services is looking for efficiencies and ways to deliver more for less as a way of dealing with our unprecedented demand, so we need to be smart in the way we spend our public health money as well. Nowhere is immune to that. We all have to be imaginative and make sure that the outcome is an outcome where we have improving public health. We have a very strong track record and we have to make absolutely sure we do not undermine it.

Q73 Chair: Thank you, but is it something you will be including in your discussions about the spending review? I think Simon Stevens phrased it as something you would not like to see happening going forward. Would you make the case to your colleagues that this could have an impact on achieving the aims of the Five Year Forward View?

Jeremy Hunt: I would certainly not agree to cuts in the public health budget that undermine the prevention agenda, which is central to the forward view, but I would also say that we need to be imaginative in the way we spend that money, so that the public health budget is making the same efficiency improvements for every pound spent as we are asking from the rest of the NHS.

Q74 Chair: Further to your response about the one-in, two-out regulations, the concern is that now organisations like the tobacco industry, or the drinks industry going forward, would be able to claim that it has had an effect on their profits, so it is about the effect of a regulation on their profits. In other words, if we are not allowed to affect the profits of the drug and alcohol industry, how on earth are we going to achieve what we want to achieve? Do you not think there should be a public health exemption for the one-in, two-out rule?

Jeremy Hunt: When we are analysing how the one-in, one-out or one-in, two-out rule works, it is not specific to the profits of an individual company, so that rule does not guarantee that any company will have a net neutral effect as a result of Government changes in regulation. We look at the cost to the economy as a whole. We have very strong arguments in public health about the costs of smoking, for example, in terms of the costs on the NHS. The new regulations that we are introducing from October will reduce the costs to the NHS of smoking by, I think, helping to reduce smoking rates still further. We can make those cost-benefit analyses.

Q75 Chair: I am sorry to interrupt, but if you then have to relieve the burden on the industry in another way, on the same industry, how is that going to take forward the public health agenda? Should we not exempt industries like big tobacco and alcohol where there is clearly a public health interest and purpose in what the regulations are seeking to achieve? Is it not going to undermine that if we do not exempt public health?

Jeremy Hunt: We do not have to make sure that there is no net cost to any individual industry or company. When we are looking at those regulations we look at the net cost to the economy as a whole, and that is why we are able to take into account the very

significant public health benefits that you get—cost benefits, if you want to look at it financially—from reducing smoking rates.

Q76 Chair: So that I am completely clear about this, when you say you are putting an additional regulatory burden on, say, tobacco, it means you could actually take two off in a completely different industry.

Jeremy Hunt: Correct.

Q77 Chair: Thank you for clarifying that because it has been a major concern when people have written to this Committee. Can I move to a different area—adult social care? Could you explain to the Committee the process leading up to the decisions around abandoning the cap on social care costs at the very end of the last Parliament?

Jeremy Hunt: Yes. We have not abandoned the cap on social care costs. We have delayed the implementation until April 2020, but we are still committed to that policy, and we can talk about the policy in detail, and why we are still committed to it, if it would be helpful to the Committee. In terms of the process, we were written to on 1 July by the LGA who talked about the pressures of funding in the social care system more generally, and their concerns, given the constraints on public finance, about being able to fund social care adequately. Their request to the Government was to delay implementation of the Dilnot cap, which was going to have significant costs on them, because they wanted to put those resources into supporting their core social care services. We reflected after receiving that letter, and we decided on balance that they were right; it was going to be a pressure on local authorities in this immediate period, and the time to proceed with the Dilnot cap, which we still want to do but with a modification that I am happy to talk to you about, would be after we had cleared the deficit, so that we were out of the period when there was immediate pressure on local authorities for their social care.

Q78 Chair: It would be helpful to hear about what the further qualifications on that would be because this is a matter of great concern to many people.

Jeremy Hunt: We completely support the Dilnot analysis, the Dilnot review and the principle of a cap, but one of the other factors in our consideration was the fact that the financial services industry had not yet developed the kinds of products that we felt were necessary in order to make the cap work in principle. The objective that we are aiming for—we need to be clear that it would be a very big thing; I think we would be one of the first countries in the world to succeed in doing this if we do—is to create a culture where it is as normal to save for your social care costs as for your pension. The objective of the cap at £72,000 was to make it easier for the financial services industry to develop products that meant that everyone was covered for their £72,000, so they did not have to worry about any of their social care costs because anything up to £72,000 would be covered by a product they took out with the financial services industry, and anything above that would be covered by the state. We need to develop a system where it is part of the process of getting a pension. We see pensions as being how you support yourself when you retire, which is about the years when you are healthy and well but also potentially about the years when you are not healthy and well. I would like to have discussions with the pension industry in the extra time that we have to see whether we could develop a new generation of products where it was just a part of your pension that you are supported for the costs of

your social care cap, and that we do not ask people to go through the complexity of a separate product for the social care bit, if you like, right at the very end and we just make it part of the product. A lot of thinking needs to happen if we are going to make it happen, but I am confident that we can make some progress.

Q79 Chair: Thank you for clarifying that, but on a process point, a lot of people were unhappy about the announcement being made two days before the end of Parliament as a written statement in the House of Lords. Do you feel that was the right way to announce it?

Jeremy Hunt: I can understand why people might feel that, but perhaps it would help if I explain. There were two reasons why we got the announcement out quickly. The announcement was made within two weeks of the decision being made, so it was very quick. We wanted to make it before the summer break because we thought it was right first of all that Parliament should know rather than sitting on a decision like this over the whole summer. Secondly, because we had allocated money to local authorities to spend in preparation for introducing the cap next year, we did not want them to go ahead and spend that money. They have spent a very small proportion of it but we did not want them to go ahead and spend that money if we were not planning to proceed in April 2016.

Chair: Thank you. We have a quick supplementary from Philippa and then we will return to the wider issues about funding of social care.

Q80 Dr Whitford: On that same issue, you yourself made a statement to the House on 16 July, which was obviously the one that resulted in all the challenging reaction from staff. Could this not have been included in your statement to the House of Commons—the elected representatives—rather than made the following day in the Lords?

Jeremy Hunt: People would have been equally cross if I had done that, because they would have said that I was burying an important announcement in another very big announcement about seven-day services, which was a big issue because of all the things that have transpired since then. I do not think there was an easy way round this. The important thing was to get the announcement out before we went away for the summer break, so that Parliament knew about it and local authorities were able to not spend the money that had been allocated in that way and find other better purposes for that spending.

Q81 Dr Whitford: Do you not think that Friday afternoon in the Lords looked like burying it?

Jeremy Hunt: Not at all. We are having a very good discussion about it now, and there are plenty of further opportunities to raise the issue as we go forward.

Q82 Chair: Thank you. Returning to perhaps the most pressing issue, which is the gap in social care funding, could you set out what your current projections are about the size of the widening gap in social care funding?

Jeremy Hunt: It is important that we look at this not in terms of a funding gap but in terms of a provision gap. We have to recognise that over the next five years we are going to have significant growth in the older population. That will put significant extra pressure on the social care system, and the NHS and the social care system are joined at the hip. It is not

possible to say that we are going to protect the budget of one side of the partnership and ignore what happens on the other, because there is a direct impact on the NHS if we do not have a proper settlement for social care, and there is a direct impact for social care if we do not have a proper settlement for the NHS. That is obviously extremely challenging given the—

Q83 Chair: I am sorry, but there is a provision gap partly because there is a funding gap.

Jeremy Hunt: I am not saying there is not a link, but the issue is about the level of provision that we need, and we need to make sure that we get that right. Yes, getting the right settlement in the CSR is a very important part of that, but another important thing, which Jon Rouse is heading up for the Department of Health, is the integration of health and social care, because having systems that are not joined up is hugely wasteful, and that is something we will be proceeding with apace during this Parliament.

Q84 Chair: Going back to my original question, at the moment where do you see the gap? I take your point that you think a lot of this is about provision, but around the actual funding gap in social care, do you recognise the figures that the LGA quote on the funding gap?

Jeremy Hunt: I know the LGA are doing their own analysis, and the Department for Communities and Local Government will obviously look through those numbers very carefully. It is not for me to say whether DCLG agree or not with those numbers, but I can say, as Health Secretary, that if we have a deterioration in social care provision relative to the increasing pressure that we are going to see because of the ageing of the population, that would have a direct impact on the NHS.

Chair: Thank you. I do not know whether colleagues want to come in on this.

Q85 Dr Whitford: Yes. Five Year Forward is totally predicated on a stronger dynamic in public health and prevention, and a diminution of demand for secondary care through better social care. The problem is that it seems that these budgets are taking a particular hit. Our issue is not that people live longer: it is that we do not live terribly well and we have this long tail of ill health. If we do not start doing something about wrapping around our older people and preventing our younger people getting ill, we are going to be sitting here in another 10 years.

Jeremy Hunt: I hope we are not, because I completely agree with you. It is incredibly important that now, as we settle not just our spending plans but also our strategy for the whole of this Parliament, we do not fall into the trap that you have described. It is really important that we have a very active prevention programme, that we have good plans for the social care system and that we have good plans for transforming primary care. That is why I spent a lot of time, not just this side of the election but also prior to the election, talking about and working out what we need to do to see the transformation of general practice—the recruitment of the additional GPs that we need. We published those plans over a year ago, talking about a 10,000 increase in the primary care workforce and delivery of effective continuity of care for people with multiple long-term conditions. It is an absolutely essential part of our plans.

Q86 Dr Whitford: It is just that these are three areas where we hear their budgets are going down: primary care does not get a bite of the cherry, or public health and social care, yet you have to bail out secondary care. While we are talking about that, we are not managing to see it changing round, because it is always the things at the edges that are the easiest to leave without money.

Jeremy Hunt: That is the great danger. That is what we have to make sure does not happen. If you want some clear evidence that we are determined not to make it happen, it is the money—£200 million—that we put into the 29 vanguards projects, which are about transforming the model of care outside hospitals this year for the first time; it is the speech I gave outlining how we are going to recruit 5,000 additional GPs, which is the biggest expansion in the GP workforce in the history of the NHS; it is the continued progress we are making on the public health agenda, not just in terms of the results but in terms of what I have talked about with an obesity strategy and the new regulations coming in around smoking, and indeed the integration of the Health and Social Care Act. There are lots of things that we are doing, but I think your broad point is right. This does not work if we carry on allowing the vast majority of additional resources in the NHS to be sucked into additional secondary care capacity, because that is more of the same. We need to transform the care we give people outside hospitals as the most effective strategy.

Chair: Thank you.

Q87 Emily Thornberry: We all talk about the importance of integrating health and social care, yet don't you think it is remarkable that the Department of Health is unaware of the extent of the cuts in social care? If you are really trying to integrate health and social care and you do not know what is going on in social care, how can you in a leadership role be helping to integrate it?

Jeremy Hunt: I did not say that I was unaware of the finances in the social care system. I said that it was not for me to make a judgment on the figures about the finances in the social care system presented by the LGA to the Department for Communities and Local Government in the middle of a spending round. That is for them to discuss and agree. I said that as Health Secretary I am absolutely clear that any deterioration in social care provision has a direct impact on the NHS. It goes back to the point that Dr Whitford was making, that the Five Year Forward View is predicated on the social care system continuing to deliver the levels of care that it currently does, and it is very important that we end up with a settlement that allows that to happen.

Q88 Emily Thornberry: In your representations to the Treasury, you are supporting the LGA when they complain about the problems they are having with the cutbacks in social care because of the cuts to local government.

Jeremy Hunt: In my representations to the Treasury, I am talking about how the health and social care systems are joined at the hip, and how it is not possible to have a financial settlement for one side of that partnership without thinking about the impact that it has on the other. The Treasury completely understand and agree with that.

Q89 Chair: On that point, one aspect where it is joined at the hip is in the better care fund. Have you made a decision about the better care fund going forward?

Jeremy Hunt: Yes. The better care fund will continue, but it is important to say that the better care fund is a transitional arrangement as we move to the full integration of the health and social care system. It is a way of progressing what we want in integration, which is fully pooled budgets, full sharing of electronic health records and accountable doctors responsible for people across the health and social care system—the basic elements of a properly joined-up system. It is part of that journey, but the end point is full integration, not the better care fund. I hope there will be a time when we do not have a better care fund because we have moved to a fully integrated health and social care system. Certainly it is our commitment, our manifesto commitment, that we deliver that during the course of this Parliament.

Q90 Chair: Before we move on to the next group of questions, I have one follow-up point. Although I accept that some of the discussions around social care concern another Department, there is one aspect that is controlled by Health, and that is personal budgets for many people and the issue of cross-subsidy as it affects personal budgets. I am hearing concerns from patients who tell me that they cannot have the care they need because the amount that they are allotted does not cover the time for those who would be providing that care. They are allotted a certain number of hours but they cannot have that many hours because they cannot get anyone to work for that rate of pay. Is that something that concerns you?

Jeremy Hunt: I am very happy to take that issue away. The general point about personal budgets is that they are a very important part of the future for patients with complex long-term conditions. There is a huge amount of evidence that says the outcomes are better, the sense of autonomy is higher and that people spend their own money more wisely than if it is spent for them by someone else. Getting a system of personal budgets to work is not easy—there are lots of complexities and we need to make sure that the system is not abused—but it is a very important part of putting patients in the driving seat of their own healthcare.

Chair: I have written to you this week about a case, but I will not detain the Committee with that today and I do not have the individual's consent. We will move on to the next question, which is about access to treatment and waiting times.

Q91 Maggie Throup: NHS England produced a report recently that showed, unsurprisingly, that demand is going up, whether it is ambulance call-outs, diagnostic tests or A&E attendances. This is not going to go away. What are your plans for the next 12 months with this growing demand for NHS services?

Jeremy Hunt: The first thing, to go back to our earlier discussion, is to make sure that hospitals have the funding necessary to deal with the increasing demand we are seeing, but it shows the importance of the broader points that many members of the Committee have made about doing everything we can to reduce demand by earlier intervention. In the case of the ambulance service, we are moving to a lot of "see and treat" and "hear and treat" models, where people are treated by paramedics on the spot rather than being ferried to hospital for their treatment, or they are given advice on the phone that means that the paramedics do not need to be dispatched. That can make a difference. It is perhaps a bit

early to say whether this is sustained, but we are seeing some early signs that the better care fund may be having an impact on reducing hospital demand. It is early to give a definitive view on that, but we need to progress with it. We need also to progress much faster with the joining up of the system. You talked before about silos in the NHS. We are learning now how important it is for different parts of the NHS locally to talk together to deal with these pressures, but obviously as we go into this winter a very important priority for me is to make sure that the system is as well prepared as possible.

Q92 Maggie Throup: Obviously the continuing demand on the NHS is affecting waiting times, so is it now the case that referral to treatment waiting time targets can only be achieved for some patient groups by allowing breaches for other patient groups?

Jeremy Hunt: We did last year allow some trusts to have managed breaches, because under the system that we had previously, which we have now changed, there was a perverse incentive where, when someone missed their 18-week target moment, trusts were not incentivised to treat them quickly even though they may have been people with the highest clinical need. We have changed the system to remove that negative incentive. Broadly speaking, the average waiting time in the NHS now is 9.1 weeks for elective care. That is low; it is broadly stable and we are treating record numbers of people, more than 1 million more procedures every year compared to five years ago, and still managing to maintain those waiting times. A lot of effort is going on in the NHS to make sure that we do not go back to the bad old days of people having to wait too long for their elective care.

Q93 Maggie Throup: Will you be allowing further breaches?

Jeremy Hunt: No. We are asking everyone to stick to our objective, which is that people should not have to wait more than 18 weeks once they are referred for treatment.

Q94 Maggie Throup: But what if they do not?

Jeremy Hunt: We have all sorts of things in place to try to do that and, as with all the kind of big national benchmark targets, when people miss them we try to identify whether it is a one-off or whether it is a sustained problem, and then if there is a problem we try to give support to trusts to address those problems. It is the same approach to the A&E target as well; a huge amount of work goes into making sure that people have the support to try to turn the corner.

Q95 Dr Whitford: Do you foresee an impact on that of moving to seven-day working, in the sense that if more consultants—particularly those who provide elective work, like orthopaedic surgeons—are rostered to work at the weekend they will be doing fewer hours during the week? Do you think your waiting times are going to go up?

Jeremy Hunt: I do not think they should because, as we move to seven-day services, we are also increasing the capacity of the system. We are planning to recruit thousands more doctors into the system during this Parliament, as we did in the last Parliament. We are going to see over this Parliament significant increases in activity done by significantly more clinical staff. We had 23,000 more staff overall in the last Parliament. What I hope we will see, though, is a difference in the pattern. As we move to better out-of-hospital care, which is what you were talking about in your last question, I hope that will mean

fewer emergency admissions, but I think we will need more elective care because we are going to need to treat more people for cancer, more hips, more knees and so on.

Q96 Dr Whitford: Is it not going to be hard to fund recruiting a whole lot of nurses and all the other staff that they require to function when in actual fact the £8 billion that has been talked about was just to stand still?

Jeremy Hunt: The £8 billion was not to stand still; it was what the NHS said it needed to transform services in line with the forward view. Actually we have given £10 billion, not £8 billion, which was the figure they originally asked for, but within that £10 billion there are also some manifesto promises that were not explicitly mentioned in the Five Year Forward View. We think it is broadly the right amount of money.

Chair: Thank you. We are going to move on to the next group of questions around mental health.

Q97 Rachael Maskell: We are all committed to parity of esteem but I want to know what steps you are taking to deliver it.

Jeremy Hunt: We are very proud of the fact that we have passed legislation that enshrines parity of esteem for mental health. I am pleased you are asking questions about it, because it has been the poor relation in the NHS for a very long time. We are not going to get there overnight, but it is important to be continually making concrete progress towards parity of esteem. I can tell you the areas where we are making the most progress at the moment. We have seen a more than halving of the number of people in a mental health crisis being held in police cells over the last few years, as a result of the crisis care concordat that was set up and negotiated by Norman Lamb when he was a Minister of State in the Department of Health. From this April, waiting times are being introduced for the first time in mental health for talking therapies and for psychosis patients, which will make a very big difference. We are also moving towards transparency of performance by developing a system, with the help of the King's Fund, so that we know the quality of mental health provision up and down the country. Just as we are able to do with hospitals, we will be able to zero in on the areas where care is not as good as it might be. In the last Budget before the election, an extra £1.25 billion was committed to improving perhaps the most troubled area of mental health of all, which is children's and young people's mental health. There are lots of plans in place to improve the services offered by CAMHS.

Q98 Rachael Maskell: Many services are still delivered in quite a traditional way. What steps are you taking to bring about early intervention strategies?

Jeremy Hunt: That is the key issue with mental health. Because we have not traditionally had waiting time targets, money has tended to be sucked into the bits of the NHS that have had waiting time targets, and we know with mental health that the chance of curing someone of an illness completely, with a full recovery, is much higher the earlier the intervention. I would say that the extra—*[Interruption.]* Apologies for the coughing. It is not very good for the Health Secretary to be coughing.

Dr Whitford: There are a lot of medics here.

Jeremy Hunt: That is true. I am safe—unless you poison me.

Can I bring in Jon Rouse, who has been very patient, because he heads up our mental health strategy? It is fair to say that the bulk of the £1.25 billion announced in the Budget will go to speeding up early intervention, particularly for young people, because it is so important.

Jon Rouse: Let us break it down into younger people and adults. For young people, we now have in every area in the country a requirement, through the CCG leadership, who are working with all the other partners and young people and their parents, to put together a transformation plan. Before NHS England started the process of planning and distribution of money, we commissioned the taskforce that produced "Future in mind", which basically said, "It is up to you how you do it, but the traditional four-tier model may not be the best way in future. Here are some best practice examples of how you might do things differently." We pointed to the THRIVE model as one approach that allows much more flexibility in terms of enabling young people to have different forms of provision at different times that suit them and their family. It links with the local school and has much better access to universal provision at the local level, which may have CAMHS professionals in it but actually may not have CAMHS on the door; it may be a more universal service that has mental health provision within it. That is about young people, and we are going to see lots of different local responses to that challenge, but with the extra money to make it happen.

For adults, the two things the Secretary of State has already mentioned are examples of early intervention. Introducing waiting times for talking therapies is not just about providing a decent service; if you want to get recovery levels up, referral needs to be made within the first six weeks because we know that the earlier the intervention, the more chance of successful treatment and recovery. We also know that that potentially unlocks other things, like getting back into work or whatever the other benefits might be. Ditto early intervention in psychosis. All the evidence points to far better outcomes if the process of referral to treat is very rapid, hence the focus on that first two weeks in terms of presentation. We will have to do more, and we now have a mental health taskforce led by Paul Farmer under the Five Year Forward View. They are due to report at the beginning of November. They will give us some guidance, and give the NHS guidance as to where we need to look at more early intervention programmes or standards.

Q99 Rachael Maskell: Thank you for that. In my constituency, people have written to me to say they have been waiting 12 months for access to talking therapy, so obviously these targets are positive, but again it is going to mean a lot of resource being put forward. Therefore, I was interested in the FOI that was run just a few weeks back, which showed that a third of CCGs had cut their funding for mental health. How are we going to achieve the outcomes with that funding cut?

Jon Rouse: The CCGs increased their funding last year, which were the last out-turn figures, and they are under an obligation, in terms of the planning guidance, to increase their funding again this year. Both NHS England and we will be monitoring that very closely, because it is a clear commitment. I do not, obviously, want to comment on the FOI data directly, but that is the commitment that has been made.

Q100 Rachael Maskell: It is clearly not being achieved in all areas. I want to ask one more question about moving forward; it is a little bit reflective of a situation in my constituency, but I dare say elsewhere too. We have a mental health facility that was built in the 18th century and still has the words "Asylum for the Insane" written above the door. I am wondering what you are doing about the estate for mental health.

Jeremy Hunt: I know that you have campaigned on that in your own constituency. I recognise that parts of the estate are not good, not just in mental health but in many parts of the NHS. It is very important that we continue to renew the estate. Locally, the NHS looks at all these bids, and we want to do as much as we can within the constraints we have. One of the challenges we have—this is a discussion where we are being very open about the many challenges we have—is that one of the competing capital requirements at the moment, which is very important in mental health, is for investment in IT so that people have proper electronic health records. That has the most impact on people who have multiple contacts with the NHS, because then there is a proper record of all their contact with the NHS which they are able to access wherever they go in the system, whether it is an A&E department or a psychiatrist. But we have a big capital budget, and there are lots of demands on it.

Q101 Dr Davies: I have a question about waiting times, if that is okay. We have already referred to physical illness waiting times and how they have been pretty resilient considering all the challenges. In terms of mental health, clearly some areas are performing well in terms of IAPT referrals, but there is a marked disparity. I do not know if we really touched on quite how we are going to ensure that there is a bit more of an equal service provided across England.

Jeremy Hunt: Because of the commitment to have maximum waiting times for IAPT and for psychosis, we are now starting to collect data for the first time. We do not currently, I believe, have the data because we are just starting to collect it, so we do not know what the baseline is, but as soon as we collect that data we will know exactly how long the waiting times are in different parts of the country, and then we will be able to monitor the areas that are not delivering what we have committed to do.

Q102 Emily Thornberry: Speaking to GPs, I understood that there was going to be an extra year's training given to them, because when they were asked about it they said the biggest part of their work was paediatrics and mental health and they did not feel they were specifically being trained on that. The answer from the Government was that there was going to be an additional year, but that has not materialised. Are there plans for that to happen, and when might it be introduced?

Jeremy Hunt: My understanding, I think, on the latest figures I saw, is that about between 10% and 20% of a GP's work is on issues linked to mental health, so it is very important. We are having ongoing discussions with the Royal College of GPs about how to incorporate that into training.

Q103 Emily Thornberry: Is that the extra year?

Jeremy Hunt: Yes, I know one of the proposals is to take an extra year to do it. Obviously, we have another priority, a very big priority for GPs, which is to get 5,000 more GPs into the workforce, a net increase of 5,000 GPs. If you add a year to the training requirement

for all new GPs, it makes it more difficult to deliver that commitment. If we are not able to add that extra year, because of wanting to make sure we deliver on our 5,000 GPs, we will need to make sure that the training new GPs get reflects the very real increase in need that they have to be properly trained in mental health areas.

Chair: There is a final question from Maggie in this group before we move to the final group.

Q104 Maggie Throup: You touched on the role that the police have with regard to mental health. Talking to my local police inspector recently, he was concerned that there is still an awful lot of time spent, as he called it, babysitting people with acute mental health problems without ready access to mental health services and support for patients. That does not seem quite the right way to address the situation. Is any extra funding being put in to make sure there is more support locally in acute situations for mental health patients?

Jeremy Hunt: Yes, it is, and we have been making some very good progress. You are absolutely right; a police cell is not the best place for someone who is having a mental health crisis. We have had some success in reducing the use of police cells. There are still occasions when it may be the only suitable option for safety reasons, but we want to minimise that and, if we can, eliminate it. We have found that the process of closer working with the police has been very beneficial both to the local NHS and to the police, because it has given mutual understanding of how mental health issues work. Where the pilots have been most successful, I think the results have been very encouraging.

Jon Rouse: Can I give one example of that? It is street triage. We set up in nine pilots, working jointly with the Home Office, where police and nurses go out together on to the streets and to home visits, often being first on the scene. The results were so successful that another 17 forces have now introduced this without any additional resources from central Government, because they could see for themselves the better outcomes and the pressure it was taking off the system.

Maggie Throup: I will have to have a word with my inspector and suggest he does that himself.

Q105 Chair: I have a final brief point. You will be aware of the comments of Stephen Dalton, the Mental Health Network chief executive, who felt there was lack of transparency about how the money was being spent. Do you recognise those comments, and how are we going to be able to see that this £1.25 billion has gone into mental health services and where it has gone?

Jeremy Hunt: We are incredibly transparent about how we spend money in the NHS, but I think there is a broader point about transparency, which is that we do not know at the moment which parts of the country are delivering high quality mental health care and which parts are not. Therefore, we are not able to focus on turning things round where provision is not as good as it needs to be. As a GP, I am sure you have been told good things and bad by your colleagues about the process of GP inspections, but it has introduced an element of transparency which we now have for hospitals and care homes. We do not have that transparency yet in the provision of mental health services, and that is a change I am very keen to make.

Q106 Chair: There is transparency for provision but do you feel that it should be there for the finances as well—where the money is spent?

Jeremy Hunt: Yes, but it is, because we know how much CCGs are spending.

Q107 Chair: So you would disagree with the comments that he made to the *HSJ*.

Jeremy Hunt: I do not have the specific comments in front of me, but I would say that we do know how much is being spent by every CCG on mental health. We monitor it very carefully, and in terms of how much we spend nationally the numbers are there for you and the Committee to see.

Chair: Thank you. We are going to move to the final group of questions around national accountability and leadership.

Q108 Emily Thornberry: I have a couple of questions. We have talked about the morale of the workforce, the people who have been called to public service, and I wonder if you would agree that one of the problems—it is what they say when they speak to me—is the problem of stress. The problem with stress of course is that compassion can go first, although competence goes last. Perhaps the leadership nationally from you, as the leader of the national health service, is not always what it ought to be, in that people hear you talk about Mid Staffs a lot—for example, during this session you have mentioned it 12 times—which does not necessarily reflect the reality of the other 150-plus acute trusts. They hear a lot of initiatives being announced from your Department which are destabilising, and they do not really understand how they are going to be put through. Do you think there might be a problem with that style of leadership?

Jeremy Hunt: Can I respectfully disagree with that comment? Let me explain why. Mid Staffs was a terrible moment for the NHS. It would have been completely the wrong thing for me as Health Secretary to run away from it or to pretend that it was not a very serious moment. I want this to be a moment of real change in the NHS, which inspires us in the NHS to go forward and deliver the highest and safest standards of care anywhere in the world. There is a lot of evidence that that is starting to happen. Where it is happening, it is motivating and inspiring for the people who work in the NHS. The point about morale is this, and this links to your leadership point: the way to increase morale in the NHS is to give confidence to doctors and nurses that they have a Government that is committed to supporting them to deliver the high standards of care that made them want to become doctors and nurses in the first place. Under the leadership of this Government they can see they have a Government that is totally committed to the NHS delivering the highest quality care anywhere in the world. We need to make it clear that that is our ambition for them and for the NHS, and we are supporting them to do that. Of course it is tough as you go through a transition when you have big financial pressures, but there is something else a Government can do as well, and we are doing, to transform morale, which is to back the NHS with the resources that come from a strong and growing economy. Because we have taken difficult decisions over the economy, we are able to promise significant real-terms increases in funding to the NHS, which means that we have near record numbers of doctors and nurses and we are going on recruiting more doctors and nurses. In the end, that is how you transform morale. It is by facing up to problems and not running away from them. Doctors and nurses are inspired with the vision of an NHS delivering high

quality care and a Government supporting them to do that. Of course it is difficult, but I am absolutely determined that we will support them and, as a result of that, increase morale. If you like, it is show, not tell, by showing we have the vision and we are backing that vision with the money from a strong economy.

Q109 Emily Thornberry: May I ask another question? We were talking about problems. The last time I looked, there was a petition of 220,565 people asking you to resign. I wonder how many more ought to sign it before you might consider it.

Jeremy Hunt: That was said with a great smile on your face, Ms Thornberry. Let me tell you, when you have a difficult argument to win over seven-day care, when you are asking doctors to change their contracts in order to deliver higher quality care, of course that is going to be controversial. But in the end I have not met a doctor who does not think we should be offering seven-day services in the NHS, who does not want to deliver the safest possible care, and I am very confident that when the issue dies down people will say actually this was a difficult thing to do but it was the right thing to do because as a result we are delivering safer care for patients.

Q110 Paula Sherriff: I am conscious that it has been a long afternoon so I will try to be brief. I want to ask about the use of management consultants in the NHS. My local hospital trust, which is the Mid Yorkshire Hospitals NHS Trust, has, I understand, spent £12 million in the last four years, exclusively using Ernst & Young. I was working in that hospital trust, and on one occasion—I was in the kitchen making a cup of tea—I got involved in a conversation in which somebody told me they would not get out of bed for less than a four-figure sum a day. I do not doubt that they do valuable work, but could the trust not look at employing a team of people and save somewhere in the region of £10 million? This is the same trust that recently implemented disabled parking charges, hoping to recoup £98,000, and in July spent £1.2 million in one month on Ernst & Young. From a non-partisan perspective, I would be really interested both in your view on that particular contract, which the trust will not give me any information on, surprisingly, and also from a wider context what is your view on the NHS using companies like Ernst & Young?

Jeremy Hunt: Yes. Hopefully, everything I have said this afternoon has been from a non-partisan perspective, but I agree with your basic point. I do not know the details of the individual contract.

Q111 Paula Sherriff: Can we meet perhaps another time to discuss it?

Jeremy Hunt: I am happy to look into that issue and respond to you on it, but I can tell you that I agree with your broader point about management consultants. In fact we introduced a freeze, and David can tell us more about measures that we introduced this year with respect to management consultancy spend. Too often in the NHS there has been a reflex, when a difficult change needs to be made, to hire someone from outside to come in and say what needs to be done, when actually the best people to decide what needs to be done are, in my experience, the people who work inside an organisation, because they are the ones who have to implement it and therefore they are making decisions not in a vacuum but with a knowledge of the things that are going to be difficult. All these things are really much more about implementation than strategy.

Paula Sherriff: I absolutely agree.

Jeremy Hunt: I think we have been spending too much on management consultancies, but, David, do you want to add to that?

David Williams: It is a measure we introduced in-year—the arrangement to introduce an approval threshold. It is above £50,000 for an individual contract.

Q112 Paula Sherriff: Is that for new contracts though? This is obviously an existing contract.

David Williams: For new contracts, it needs to come up to either TDA or Monitor. I do not think that is something that we will simply want to put in place for this year and then relax. I see it as a continuing part of the landscape, and we will want to review whether the financial threshold is in the right place.

Q113 Dr Whitford: Following on from Ms Thornberry's point, you mentioned in your response that obviously doctors and nurses want to provide the best care, and you have agreed over this afternoon that the first focus should be on looking after those who are ill seven days a week. I still come back to why you feel it is necessary to change the contract, because for people in the NHS that feels threatening. We know the figure that only 1% signed the opt-out, and therefore they feel it is actually an attack on the fact that they get paid more at the weekend; it is not exorbitant—one-to-one negotiated—but they do get recognition for out of hours. For people who are already working seven days a week, nine out of 10, their money would actually go down. Do you not recognise that what was said in July felt like the pin being pulled out and a grenade being lobbed at staff who actually already work 48 hours-plus a week?

Jeremy Hunt: I recognise that it may have felt like that, given the way that it was presented by the BMA, but if you look at the words that I said—

Q114 Dr Whitford: I was in the Chamber, and I have to say I felt it was like that.

Jeremy Hunt: If you looked at the words that I said, it was very far from a grenade. There was very strong recognition of the hard work done by doctors at weekends. There was a desire to give more support to doctors who work at weekends. But I was acting on the basis of the advice that I received from the people who run hospitals, who said that of the many things we need to do to have proper seven-day services, the opt-out in the consultant contracts—let us remember that consultants are the only people who have that opt-out, junior doctors do not have it—

Q115 Dr Whitford: But they are not opting out of emergency care.

Jeremy Hunt: Junior doctors do not have it, nurses do not have it and paramedics do not have it. It is only the most senior people, who actually are the most important people of all when it comes to that expert advice, the first assessment that you have in an emergency situation. We do not have the cover that we need at weekends for emergency care, and hospitals were very clear to me that the biggest single obstacle to delivering it is that opt-out in the contract. That was why I took the decision that I did. As I say, I think it will be seen as the right thing for patients. If you also look at the morale issue, it is very clear

that, when you take difficult decisions that mean you are giving better care for patients, in the end morale goes up. If you look at places like Northumbria that deliver seven-day services, morale went up after they introduced seven-day services. When you have a big argument like that, while there is a short-term impact on morale because of the way the issue is portrayed, the long-term impact, as services are improved for patients, is a good one and I think it is my job as Health Secretary to lead the NHS in a way that does the right thing for patients. In the end that is the only way that we will improve morale among doctors and nurses.

Q116 Dr Whitford: Which is why I feel it could have been done at local level through discussion. Most people want their service to be good and to look after patients.

Jeremy Hunt: I have to follow the advice I get about what I can do at a national level, and I was getting very clear advice that that opt-out in the contract was the single biggest obstacle to delivering that care for patients, but I agree with you that it is not just what I do at a national level; it is also what happens locally.

Q117 Chair: Thank you. Can I go back to the issue about leadership and management in the NHS? Do you agree with Lord Rose's opinion that there was insufficient management capability in the NHS? To follow up from that, do you feel, given the fact that there have been 18,000 administrators and management staff taken out of the NHS, that we went too far in that process?

Jeremy Hunt: I do not think we went too far in that process, because if you look at where most of those administrators were taken out of the system, they were taken out of the commissioning system rather than the provision. It was in the big bureaucracies in the old SHAs and PCTs that the brunt of those people were made redundant. But I agree with Lord Rose's general point. Being a manager in the NHS is probably one of the most difficult places you could be a manager anywhere. You are not just dealing with profit and loss, balancing your books and dealing with customers, you are also dealing with the life and death issues that you get with patient care on a daily basis. It is an incredibly challenging thing do. We have some brilliant managers in the NHS, but we have not been as good as we need to be about bringing out the best in management. Lord Rose's report had a lot of suggestions as to how we could nurture the next generation of managers, in terms of having more coherent career plans for managers as they pursue their careers in different parts of the NHS; making it easier for clinicians to become managers and looking at some of the things that act as barriers to clinicians becoming managers; and improving the training process, which is why we took the decision to move the NHS Leadership Academy to Health Education England, to streamline responsibilities in those areas. There is lots we are doing in that respect, but I agree with you that getting high quality management is very important.

Q118 Chair: Would you also recognise the need not just to have managers who have time for the day-to-day running, which is vitally important, but also the time to make the transformational change? Do you agree there is a shortage of people who have the time and capacity to do that?

Jeremy Hunt: Yes, and I think the challenge is that if you are running a busy A&E department, or a hospital which has a busy cancer department, a busy A&E department

and a busy maternity, to a certain extent it is very tempting to get sucked into dealing with all the operational issues and not deal with the big strategic changes that need to happen in the next two to three years. We need to give the people running big NHS organisations stability of leadership, so that they know what the plan is and know how the Five Year Forward View is going to be implemented in their part of the NHS over the next few years. They can make the necessary changes, the efficiency savings and the improvements in care that they want, without things chopping and changing at the centre. They need that stability. That is something that we can and must offer them.

Q119 Chair: Thank you. Do colleagues have other questions they want to add? Is there anything you would like to say to the Committee before you leave that we have not covered this afternoon?

Jeremy Hunt: No. I think it is fantastic to have so much NHS experience on a Health Select Committee. Nearly everyone on the Committee has worked in the NHS. Am I right in saying that everyone has worked in the NHS in the past?

Emily Thornberry: Not me.

Jeremy Hunt: Not you, Emily, but nearly everyone.

Dr Whitford: That is why the NHS is in trouble: we are all sitting here.

Chair: Yes. Thank you very much for joining us today. We are grateful for your time. Thank you.

Q120 ***Jeremy Hunt***: Thank you very much.